Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Instructions for completing form MAP 109-HCBW

The MAP 109-HCBW is used by Medicaid providers participating in the Home and Community Based (HCB) Waiver program. The Plan of Care/Prior Authorization for HCB Waiver Services (MAP 109-HCBW) is designed to be complete and thorough instrument that is utilized:

1. For the member's attending physician, physician's assistant (PA) or advanced registered nurse practitioner (ARNP) to certify the member meets nursing facility level of care;
2. To document the physician, PA or ARNP has reviewed the Plan of Care in accordance with 907 KAR 1:160;
3. To document the assessed Needs, Goals, Interventions and Outcomes necessary to maintain the HCB waiver member in his residence;
4. To document the HCB Waiver services requested, the revenue or HCPCS code, the frequency and duration of the HCB Waiver service, the number of service units requested, the dollar amount requested by the provider as it relates to the units of service requested;
5. To document the Support Spending Plan for members choosing to participate in the Consumer Directed Option (CDO) by identifying the CDO services requested, the employee name, hourly wage, hours per month, monthly pay, taxes and total monthly amount;
6. To identify the Emergency Back-up Plan for members participating in CDO; and
7. Utilized by the Quality Improvement Organization (QIO) and/or Support Broker to Approve or Deny the Medicaid HCB waiver provider's service requests.

General Information Regarding the MAP 109-HCBW

For the Plan of Care/Prior Authorization for Home and Community Based Waiver Services form (MAP 109-HCBW) to be useful and meaningful to the process of service provision to Medicaid HCB Waiver members, the following points must be addressed:

1. The case manager shall complete the Plan of Care thoroughly and accurately;
2. The Plan of Care shall recognize each and every assessed need and the goal, intervention and outcome related to that need; and
3. The Plan of Care shall recognize who will be addressing the member's need. For example, the agency personnel (case manager, aide, etc.) or, if not provided under the waiver; the individual, a family member or other person/method/resource that will be used to adequately address the member's assessed need.

The Document::

- Type of submission: Check the box corresponding with the appropriate type of submission; initial **plan of care development**; annual **plan of care development** or a modification to the existing **plan of care.**
- Type of services: Check the box corresponding with the appropriate type of waiver services
- Recipient name: Enter last name, first name and middle initial.
- SSN/MAID: Enter either the Kentucky Medical Assistance Identification (MAID) number found on the Medicaid card or the Social Security number (if the MAID number has not yet been issued).
- Representative Name: Complete **only** if member is participating in the Consumer Directed Option (CDO). Enter the representative's name.
- Recipient Diagnosis(es): Enter all pertinent diagnosis(es).
- This Plan of Care covers the following period: Enter the begin date and the end date of the plan of care.
- Needs: Using the MAP 351A as a guide, enter the identified need(s);
- Goals: Involving the member/caregiver(s) in the goal development, document the goal in relation to the assessed need;
- Interventions: Recognizing applicable waiver services, family members, friends, relatives, neighbors and other community resources, document the method by which the need will be addressed in order to achieve the member's documented goal(s);
- Outcomes: Document the status of each need, goal and intervention every sixty (60) days **AND** as needed. Documented status should indicate whether need, goal and intervention is being met or not and what changes (if any) will be required;
- Requested HCBW Services: Enter each HCB Waiver service requested;
- Revenue/HCPCS Code: Enter the applicable code for the service;
- Frequency/Duration: Enter the amount of time and number of days per week each service is being requested;
- Units of Service: Enter the number of units requested;
- If, traditional HCBW are needed, enter the HCBW provider's name, provider number, address and phone number;
- If, ADHC services are needed, enter the ADHC provider's name, provider number, address and phone number;
- If member chooses Consumer Directed Option (CDO services) enter the Support Broker's name and phone number;
- Physician, PA or ARNP Statement: This is to be completed by the physician, PA or ARNP and must include their full name (printed), license number, complete address (including city and zip code), signature and date;
- Enter Total Estimated HCBW monthly cost;
- Enter the date of Plan of Care development;

- The Case Manager must sign and date;
- Member or Member's legal representative must sign and date;
- Support Spending Plan: To be completed by the Support Broker **ONLY** when member is choosing CDO or blended services.